STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013039	A. BUILDING: _____ B. WING _____	C 09/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISONVILLE MEADOWS ASSISTED LIVING	10410 ALLISONVILLE ROAD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure survey. This visit included the Investigation of Complaint IN00156300. Complaint IN00156300 - Substantiated. No deficiencies related to the allegations are cited. Dates of survey: September 24, 25 & 26, 2014 Facility Number: 013039 AIM Number: NA Provider Number: NA Survey Team: Mary Jane G. Fischer RN TC Census Bed Type: Residential: 112 Census Payor Type: Private: 112 Sample: 7 Allisonville Meadows Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of Complaint IN00156300. Quality Review 09/26/14 by Lisa McColly	R 000		